MONTANA MEDICAID

GROSS ADJUSTMENT FORM

Gross adjustments correct payment to provider independent of individual claims. Gross adjustments are utilized to eliminate credit balances, in instances when the dates of service are over 15 months or for cost settlement.

ADJUSTMENT ACTION REQUIRED:

_____ 2 – Debit (Pay Provider)

_____ 3 – Credit (Reduce Provider Payment)

_____ 6 – History Only Debit

_____ 7 – History Only Credit

FUND CODE:

_____ Medicaid

Amount:

$_____

ADJUSTMENT REASON:

CODE: _____

A – Audit
B – Rate Change
C – Cost Settlement
D – TPL Recovery
E – Claim Error
F – Retro Eligibility Change
G – TPL Recovery – State

REASON FOR ADJUSTMENT: Explain in detail the reason for this gross adjustment. Use a separate sheet of paper if necessary. Attach copies of supporting documentation.

_____ Dates of Service over 15 months old, cannot be paid as regular claim.

PROVIDER & RECIPIENT DETAILS SERVICE DATES: From: _____To: _____

PROVIDER DATA:

Billing Number _____

Name _____

Category of Service _____

RECIPIENT DATA:

ID Number _____

Name _____

County Number _____

Prepared by: _____ Date: _____

Administrator: _____ Date: _____

The administrator must approve adjustments that increase or reduce the provider payment by $500 or more. This does not include history only adjustments or credit balances/returned checks by provider.

FISCAL AGENT COMMENTS:

Completed by: _____ Date: _____

Revised 01/23/08